

# 2020 BENEFITS

January 1, 2020 – December 31, 2020

Early & Medicare-  
Eligible Retirees



**We've Got You Covered**

CITY OF  
**LONG BEACH**

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## Here's some important information you should know.

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**Medicare Part D Notice:** If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices at the end of this guide for more details.

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This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.



## We've Got You Covered

At the City of Long Beach, our employees are our most important asset, and your health and well-being are among our highest priorities. As a retiree, helping you and your families achieve and maintain good health physically, and emotionally is the reason the City offers you comprehensive, flexible benefits that keep you and your loved ones covered.

Before choosing your coverage options that are effective January 1, 2020 – December 31, 2020, we encourage you to take some time to understand your available options, how the plans work, what you will pay for coverage, where to get help, and most importantly, how to enroll.

We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Share and discuss this information with your family so that together, you can carefully make the best decision regarding your health care options.

Here are Open Enrollment highlights for 2020:

- **MDLive Now Offered to SCAN Members** for \$0 per call/visit to speak to a board-certified doctor through a computer, tablet, mobile app or through the phone.
- **Delta Dental PPO Plan** will now include:
  - Dental implant coverage at 50% coinsurance.
  - Third screening at no additional cost for future moms.
  - Diagnostic and Preventative Maximum Waiver Program.
- **Opposite Sex Registered Domestic Partners** can be enrolled in the City's health plans. Must be registered through California Secretary of State. The age 62 requirement is eliminated.
- **VSP Voluntary Vision** Benefits will now be available to Medicare-eligible retirees and their dependents.
- **A new benefits resource** that connects you and your family members to all of your benefits, services and programs through one single, toll-free number, where a dedicated health professional can help you with virtually any healthcare need 24/7. Be on the lookout for details coming soon!

While we've made every effort to make sure that this guide is thorough, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your carrier plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid and will always prevail. These can be found on our internet website at <http://www.longbeach.gov/hr/>. Plan documents can also be found on each of our benefit carrier's websites. For Anthem, visit [Anthem.com/ca/colb](http://Anthem.com/ca/colb), for UHC, [UHCretiree.com](http://UHCretiree.com), and for SCAN, [SCANhealthplan.com/COLB](http://SCANhealthplan.com/COLB).

The benefits in this summary are effective:

January 1, 2020 - December 31, 2020

# Getting Care When You Need It Now

## WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

### Anthem Medical Plan Participants

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Use Anthem LiveHealth Online
- Schedule a doctor house call through Heal
- Visit a CVS Minute Clinic
- Find an urgent care center by visiting [anthem.com/ca](https://www.anthem.com/ca) or via the Anthem Mobile Consumer Health App

### SCAN Plan Participants

- Call SCAN Member Services at 800-559-3500
- Use MDLive for \$0 per call/visit

### United Healthcare (UHC) Plan Participants

- Call UHC's NurseLine at 877-365-7949
- Use HouseCalls<sup>SM</sup> a clinical visit in the comfort of your own home
- Use Virtual Doctor Visits for UnitedHealthcare powered through Doctor on Demand or AmWell

## WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

## WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

**CVS Minute Clinic** provides you with care from nurse practitioners and physician assistants with no appointment needed. Go to [CVS.com/minuteclinic/](https://www.CVS.com/minuteclinic/) to find a location near you! See page 14 for more information.



### Anthem Medical Plan Participants

Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment. LiveHealth Online provides 24/7 access to U.S. board-certified physicians, for half the cost of an office visit! Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. It's a great option for care when your doctor isn't available. For more information, visit [livehealthonline.com](https://livehealthonline.com).

## ON-DEMAND DOCTOR HOUSE CALLS WITH

### Anthem Medical PPO Plan Participants

Heal allows Anthem PPO members to see a licensed doctor in your home, office or just about anywhere else from 8am to 8pm, 7 days a week.

- Licensed, qualified internal medicine doctors and family doctors for primary, preventive, and urgent care (includes wound care, post-surgery care, etc.)
- See a licensed physician where you and your family are most comfortable, your home
- Spend more time with you and get to know your unique health history

### United Healthcare (UHC) Plan Participants

UHC members can ask questions, get a diagnosis, even get medication prescribed\* and have it sent to your pharmacy by a doctor 24/7 using the webcam on your computer, tablet or smartphone. A virtual doctor visit with either app has a \$0 copay. Download the **Doctor on Demand** or **AmWell** apps from your tablet or smartphone or on your PC by:

1. Visiting [UHCRetiree.com](https://UHCRetiree.com)
2. Signing in with your user name and password
3. Clicking on the **Virtual Visits** toolbox to view your virtual provider group choices, access their websites and set up an appointment



## Is it Preventive or Diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's fully covered in-network.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

### Preventive care services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider



**PREVENTIVE:** At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.



**PREVENTIVE:** As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.



**PREVENTIVE:** Aki's doctor orders lab work during his annual physical, including a cholesterol check.

### Diagnostic services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost



**DIAGNOSTIC:** Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.



**DIAGNOSTIC:** Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.



**DIAGNOSTIC:** Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.



# Who Can You Cover?

## WHO IS ELIGIBLE?

You are eligible for the benefits outlined in this overview and you can enroll the following family members in our medical, dental and vision plans.

Who's Eligible?	Definition
You	Early retirees less than age 65, those not eligible for Medicare, and retired from full time employment as well as retirees 65+ and those eligible for Medicare (must have Medicare Parts A & B)
Your spouse	The person who you are legally married to under state law, including a same-sex spouse.)
Your registered domestic partner (same or opposite sex, must be age 18 or over)	If you have registered your Domestic Partnership with the California Secretary of State, please review the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Long Beach are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
Your child(ren)	Includes natural children, step-children, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship:

## WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings, aunts/uncles, nieces/nephews, and grandchildren
- Divorced spouses
- Former stepchildren as a result of divorce

## WHEN CAN I ENROLL?

Coverage for new retirees begins on the 1st of month following their retirement date. New retirees must advise HR of their enrollment selections prior to retirement. If you do not advise HR of your selections, you will not receive coverage.

Your benefits will remain unchanged until the next open enrollment period, unless a qualifying event occurs. Make sure to notify HR right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election.

Qualifying Life Events include (but are not limited to):	Time you have to make your benefit change
Birth or adoption of a baby or child	60 days
Marriage	60 days
Divorce	31 days

## DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You may be required to provide proof of one or more of the following:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate (hospital certificates are not official birth records and will not be accepted as proof of birth)
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children, and children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)
- Additional documentation such as tax returns or utility bills to demonstrate dependent eligibility may be requested

# Retiree Cost of Coverage

PLAN	MONTHLY COST
<b>Medical – Anthem Blue Cross PPO</b>	
Single Retiree	\$965.40
Retiree with 1 Dependent	\$1,206.76
Retiree with 2 or More Dependents	\$1,268.34
<b>Medical – Anthem Blue Cross Medicare Supplement (Must have Medicare Parts A &amp; B)</b>	
One Medicare (Single)	\$648.09
One Medicare & One Anthem PPO Non-Medicare Dependent	\$1,206.76
One Medicare & Two/More Anthem PPO Non-Medicare Dependents	\$1,268.34
Two Medicare (Retiree & Spouse)	\$1,295.86
Two Medicare & One Anthem PPO Non-Medicare Dependent	\$1,915.27
Two Medicare & Two or More Anthem PPO Non-Medicare Dependents	\$2,309.62
<b>Medical – Anthem Blue Cross Premier HMO – CA ONLY</b>	
Single Retiree	\$772.43
Retiree with 1 Dependent	\$1,390.38
Retiree with 2 or More Dependents	\$1,510.76
<b>Medical – Anthem Blue Cross Classic HMO – CA ONLY</b>	
Single Retiree	\$631.89
Retiree with 1 Dependent	\$853.06
Retiree with 2 or More Dependents	\$935.70
<b>Medical – UnitedHealthcare® Group Medicare Advantage PPO (Must have Medicare Parts A &amp; B)</b>	
One Medicare (Single)	\$509.62
Two Medicare (Retiree & Spouse)	\$1,019.24
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,282.05
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,791.67
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$1,900.00
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$2,020.38
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,141.51
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,651.13
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,362.68
One Medicare & Three or More Anthem Classic HMO Non-Medicare Dependents	\$1,445.32
<b>Medical – SCAN Health Plan Medicare Advantage – CA ONLY (Must have Medicare Parts A &amp; B)</b>	
One Medicare (Single)	\$385.75
Two Medicare (Retiree & Spouse)	\$771.50
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,158.18
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,543.93
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$1,776.13
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$1,896.51
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,017.64
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,403.39
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,238.81
One Medicare & Three/More Anthem Classic HMO Non-Medicare Dependents	\$1,321.45
<b>Dental – Delta Dental of California DPPO</b>	
Retiree with or without Dependent(s)	\$110.56
<b>Dental – DeltaCare USA DHMO</b>	
Retiree with or without Dependent(s)	\$38.67
<b>Vision – VSP Vision</b>	
Retiree with or without Dependent(s)	\$12.98
<b>Vision – VSP Vision Voluntary 65+ Only</b>	
65+ Retiree Only	\$10.58
65+ Retiree with One Dependent	\$21.17
65+ Retiree with Two or More Dependents	\$24.87

Note: Other combinations of health plan enrollments may be available for non-Medicare retirees with Medicare-eligible dependents, or Medicare-eligible retirees with non-Medicare dependents. Please contact the Benefits Office for additional information.

# Medical – Retirees under age 65 and not eligible for Medicare

Medical coverage provides you with benefits that help keep you healthy such as preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. City of Long Beach provides you with comprehensive coverage through Anthem Blue Cross.

## HMO PLAN

When you enroll in the Anthem Blue Cross HMO plan, you agree to use only Anthem Blue Cross doctors, facilities and medical groups for all of your medical care. You must choose a Participating Medical Group (PMG) or Independent Physician Association (IPA), and Primary Care Physician (PCP) to manage your care. Anthem Blue Cross covers most services at 100%, with no deductible, as long as you use providers who belong to your PMG/IPA. Office visit copayments are \$20, and there are no claim forms. Any care you receive without approval from your PCP is not covered. Emergency room services require a \$100 copayment per visit. This copayment is waived if you are admitted to the hospital. As a retiree, you can choose from two HMO plans: HMO Premier (similar to the active employees plan) and HMO Classic, which is a lower cost option. See details on the next page.

## PPO PLAN

The PPO plan offers you access to a large network of physicians who agree to discount their fees for services. Under this plan, you are not required to select a PCP and you can access different physicians and specialists at your own discretion. While you may go to any doctor or hospital each time you need care, your copay or coinsurance will be lowest when you go to an in-network PPO provider. As long as you use providers who participate in the network, your care will be covered at the highest benefit level – 90% after deductible for most services.

You also have the option to see a non-PPO provider, but services are then covered at 50% of Usual, Customary, and Reasonable charges (UCR), higher deductible amounts apply, and claim forms are required. Some providers may also require payment in full at the time of service. Out-of-network benefits are paid based on 90th percentile of UCR charges, which means the plan pays charges for non-network providers based on fees charged by 9 out of 10 doctors in their geographic area. This means you

could receive a bill for any charges over UCR. If the UCR amount is lower than the actual charge, the provider may take a loss or you, the patient, may be responsible for the difference. **Note: If you use non-network providers, Anthem will mail the reimbursement check to you (not to the non-network provider). It is your responsibility to reimburse non-network providers with the money you receive from Anthem.**

## ABOUT THE HEALTH CARE PROVIDER GROUPS

Here are some things to keep in mind as you weigh your medical plan options:

1. Consider the location of your physician. They should be within a reasonable distance (about 30 miles) of your home or office.
2. You must select a PCP if you enroll in the Anthem Blue Cross HMO plan. You may choose different PCPs for yourself and each of your family members, if you wish.
3. The Anthem Blue Cross PPO plan has national networks of physicians and hospitals. Network providers are often available when you travel or if your dependents live in other areas.
4. The Anthem Blue Cross HMO plan covers urgent and emergency services outside your service area when you travel.

### LIVEHEALTH ONLINE

**LiveHealth**  
ONLINE

With LiveHealth Online, members can see a board-certified doctor or licensed therapist through live video on their smartphone, tablet or computer with a webcam. LiveHealth Online is quick, easy to use and will help you get **the care you need when you need it**. Use the app for things like the flu, a cold, pink eye, rashes and more! **Doctors are available 24/7** and can even send a prescription to your pharmacy of choice. Help is available at a cost of only a \$10 copay per visit. **All you have to do is sign up online at [livehealthonline.com](https://livehealthonline.com) or download the free app.**

# Medical Summary

Plan Provisions	Anthem Blue Cross Premier HMO	Anthem Blue Cross Classic HMO	Anthem Blue Cross PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
<b>Annual Deductible</b>	\$0 per individual \$0 per family	\$0 per individual \$0 per family	\$150 per individual \$300 per family	\$350 per individual \$700 per family
<b>Annual Out-of-Pocket Max</b>	\$1,000 per individual \$3,000 per family	\$1,500 per individual \$4,500 per family	\$2,650 per individual \$5,300 per family	Unlimited Unlimited
<b>Lifetime Max</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Office Visit</b>	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$40 copay then 50% after deductible
<b>Outpatient X-ray &amp; Lab</b>	No Charge	No Charge	10% after deductible	50% after deductible
<b>Ambulatory Surgical Centers</b>	No Charge	No Charge	10% after deductible	50% after deductible
<b>Home Health Care</b>	No Charge	No Charge (limited to 100 visits/calendar year)	No charge (limited to combined maximum of 100 visits/ calendar year, one visit by home health aide equals four hours or less; not covered while insured person receives hospice care) <sup>2</sup>	50% after deductible (in-network limitations apply) <sup>2</sup>
<b>Preventive Services</b>	No Charge	No Charge	No Charge	50% after deductible
<b>Chiropractic Care</b>	\$10 copay per visit (up to 30 visits per year combined with acupuncture) <sup>3</sup>	\$15 copay per visit (up to 20 visits per year combined with acupuncture) <sup>3</sup>	10% after deductible (up to 34 visits per year, combined in and out-of-network)	50% after deductible (up to 34 visits per year, combined in and out-of-network)
<b>Acupuncture</b>	\$10 copay per visit (up to 30 visits per year combined with chiro) <sup>3</sup>	\$15 copay per visit (up to 20 visits per year combined with chiro) <sup>3</sup>	10% after deductible (up to 34 visits per year, combined in and out-of-network)	50% after deductible (up to 34 visits per year, combined in and out-of-network)
<b>Inpatient Hospitalization</b>	No Charge	\$250 copay per admission plus 20% for unlimited days	10% after deductible <sup>2</sup>	\$300 deductible then 50% after deductible <sup>1,2</sup>
<b>Outpatient Surgery</b>	No Charge	No Charge	10% after deductible	50% after deductible

# Medical Summary

Plan Provisions	Anthem Blue Cross Premier HMO	Anthem Blue Cross Classic HMO	Anthem Blue Cross PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
<b>Emergency Room (copay waived if admitted)</b>	\$100 copay per visit	\$100 copay per visit	\$100 copay per visit	\$100 copay per visit
<b>Durable Medical Equipment (Including hearing aids offered one hearing aid per year every three years)</b>	No Charge	No Charge	10% after deductible	50% after deductible
<b>Physical Therapy</b>	\$10 copay per visit	\$15 copay per visit	10% after deductible	50% after deductible
<b>Skilled Nursing Facility (Limited to 100 days/year)</b>	No Charge	20%	10% after deductible <sup>2</sup>	50% after deductible <sup>1,2</sup>
<b>Hospice Care</b>	No Charge	No Charge	No Charge	50% <sup>1</sup>
<b>Mental Health &amp; Substance Abuse</b>				
<b>Inpatient/ Facility Based Care</b>	No Charge for unlimited days; pre-authorization required	\$250 copay/admission plus 20% for unlimited days; pre-authorization required	10% <sup>2</sup>	\$300 deductible then 50% after deductible <sup>1,2</sup>
<b>Inpatient/ Physician Visits</b>	No Charge	No Charge	10% after deductible	50% after deductible
<b>Outpatient/ Facility Based</b>	No Charge; pre-authorization required	No Charge; pre-authorization required	10% <sup>2</sup>	\$300 deductible then 50% after deductible <sup>1,2</sup>
<b>Outpatient/ Physician Visits</b>	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$40 copay then 50% after deductible

1. The per confinement deductible and plan coinsurance will apply to facility charges. The calendar year deductible and plan coinsurance will apply to any physician charges.
2. Subject to utilization review.
3. Services must be medically/clinically necessary except for emergency services and initial exam. A referral from your primary care doctor is not necessary but chiropractor/acupuncturist must be in the American Specialty Health (ASH) network.

For additional information and a complete list of benefits, please visit [anthem.com/ca/colb](http://anthem.com/ca/colb).

# Anthem Wellness Programs

Anthem Blue Cross offers several wellness programs to supplement our plans. All of these programs are available to both HMO and PPO members.

## CONDITION CARE

If you have, or one of your dependents has, a long-term health problem, ConditionCare is for you. It's a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. You'll get:



Educational resources, like email newsletters.



24/7 access to a nurse care manager for health questions.



Depending on your health, you may be asked to complete a health questionnaire. Your answers will help Anthem figure out how to best support you.



Then, Anthem will put you in touch with a nurse care manager who'll provide guidance on reaching your health goals. He or she will also follow up periodically to offer encouragement and advice.

**You can participate at no extra cost, just call (800) 522-5560.**

## MOBILE HEALTH CONSUMER

Mobile Health Consumer is a customized digital health and wellness companion that empowers members by centrally connecting the Health Plan, Provider and Patient. With MobileHealth Consumer, you have access to the following:

- ✓ ID card and plan benefit summary
- ✓ Health Risk Assessment <5 minutes
- ✓ Receive coaching, condition care referrals & gap in care notifications
- ✓ Biometric and activity tracking
- ✓ Participation incentives and team challenges
- ✓ Quick access to LiveHealth Online
- ✓ Connectivity to medical care team (for HMO members only)



**Support via smartphone (iOS & Android), tablet and web – register today at [Anthem.com/ca](https://Anthem.com/ca).**

## MYHEALTH ADVANTAGE

It's hard enough remembering birthdays and all the big events in your life. Taking care of your health? That's easy to forget. MyHealth Advantage can help. It connects your claims, doctor reports, personal health history and other information for a bigger picture of your health. If we see things, you can act on to help improve your health or save money, you'll get a **MyHealth Note** — a confidential health summary that includes:

- ✓ **Money-saving tips.** For example: Can you switch from a brand-name medicine to a lower-cost generic?
- ✓ **Prescription drug updates.** Time for a refill? We'll let you know.
- ✓ **Reminders for checkups, tests and exams.** We'll keep nudging you about scheduling preventive care.
- ✓ **Lists of recent claims and prescriptions.** Share these with your doctors.
- ✓ **General health tips.** Are you at risk for diabetes or another condition? We can give you the warning signs.

The program can help you keep health issues from developing or becoming serious. And that means lower health care costs down the road.

MyHealth Notes are mailed to you. Or you can read our "Suggestions" on your iPhone or Android device by downloading the **Anthem Anywhere** app. With this app, you have the option of getting personalized health messages on the go via the Secure Message Center.

## 24/7 NURSELINE

You can call any time to talk to a registered nurse about your health concerns. You can get answers to questions, whether you're sick or not. A nurse can help you decide where to go if your doctor isn't available – just call 800-977-0027 (number can also be found on your ID card).



# Anthem Wellness Programs

## HEAL

(PPO MEMBERS ONLY)



Heal allows doctor house calls on-demand for primary, pediatric, preventative, and urgent care appointments. As a benefit of your Anthem Blue Cross PPO health insurance plan, you can see a licensed doctor in your home, office or just about anywhere else with Heal.

Heal doctors are available 8AM to 8PM, 365 days a year and are typically to your door in 2 hours, for only a \$20 copay per visit. You will always see your price before you book & never get a bill later.

For more information or to get started, visit [heal.com](https://heal.com) or download the Heal mobile phone app from the App Store or Google Play.

## LIVEHEALTH ONLINE



Use LiveHealth Online to have a video visit with a doctor on your smartphone, tablet or computer with a webcam. Online visits using LiveHealth Online are a covered benefit under your Anthem health plan. Sign up quick, easy and for free today at [livehealthonline.com](https://livehealthonline.com) or download the app (IOS and Android) so you can get access to board-certified doctors 24/7 for a \$10 copay. Doctors using LiveHealth Online can provide medical care for common conditions, like the flu, colds, pink eye and more. And they'll even send prescriptions to the pharmacy of your choice, if needed. Here are a couple frequently asked questions:

### Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online isn't meant to replace your primary care doctor. It's a convenient option for care when your doctor isn't available. LiveHealth Online connects you with a doctor in minutes. Plus, you can get a LiveHealth Online visit summary from the MyHealth tab at [livehealthonline.com](https://livehealthonline.com) to print, email or fax to your primary care doctor.

### What are some examples of what I can use LiveHealth Online for?

Use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, rashes, infections, allergies or another common health condition. It's faster, easier and more convenient than a visit to an urgent care center.

### How much does it cost to use LiveHealth Online?

**LiveHealth Online is available to the City's Anthem members for a \$10 copay, that's half the cost of an office visit!**

### How does it work?

When you need to see a doctor, there are two simple ways to access LiveHealth Online:

- ✓ Computer: Simply go to [livehealthonline.com](https://livehealthonline.com)
- ✓ Smartphone: Download the **LiveHealth Online** mobile app from App Store or Google Play

Pick the state you're in and answer a few questions. Setting up an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and set up online visits at times that fit your schedule. Once connected, you can talk with the doctor as if you were in a private exam room.

### Can I get online care from a doctor if I'm traveling or in another state?

Yes, just select the state (i.e. California, etc.) you're in under My Location on [livehealthonline.com](https://livehealthonline.com) or with the app, and you'll only see doctors licensed to treat you in that state. Don't forget to change the state back when you get home.

### Does LiveHealth Online offer any other services?

Yes, in addition to the general services that have been discussed, LiveHealth Online Psychiatry and LiveHealth Online Psychology are also available. Below are a couple facts about these additional services:

	LiveHealth Online Psychiatry	LiveHealth Online Psychology
<b>Provider Types</b>	Board Certified Doctors	Licensed Therapists and Psychologists
<b>Benefit offered</b>	Medication, if necessary after evaluation	Counseling with Psychologists and Therapists
<b>Visit length</b>	30-45 minute initial evaluation. 15 minute follow up sessions if needed for medication review	45 minute counseling sessions
<b>Ages Served</b>	Age 18 and higher	Age 10 and higher

**Please note:** Appointment wait times for Psychiatry and Psychology vary by availability

# Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs through CVS Caremark. View your COLB prescription drug benefits, including copay amounts for specific medicines, your prescription drug history, and more by registering online at [www.caremark.com](http://www.caremark.com).

## PHARMACY (RETAIL)

The City offers a three-tier prescription drug program through CVS Caremark for employees enrolled in the Anthem Blue Cross HMO and PPO plans. Members receive combo medical and prescription ID cards (Anthem Blue Cross and CVS Caremark) when initially enrolled in the City's health plan or if the member changes the health plan or adds a new dependent. When you present your ID card at a participating pharmacy, you will be charged a copay based on the type of prescription you receive.

### HMO Plans (premier & Classic)

Annual Out-of-Pocket Limit*	Combined with medical
Individual (Premier / Classic)	\$1,000 / \$1,500
Family (Premier / Classic)	\$3,000 / \$4,500
<b>Pharmacy</b>	
Generic	\$10 copay
Preferred Brand	\$25 copay
Non-preferred Brand	\$40 copay
<b>Supply Limit</b>	30 days

\*You must meet an annual out-of-pocket limit in order for your plan to cover benefits at 100%.

### PPO Plan

Annual Out-of-Pocket Limit*	In-Network	Out-of-Network
Individual	\$3,950	Unlimited
Family	\$7,900	Unlimited
<b>Pharmacy</b>		
Generic	\$10 copay	
Preferred Brand	\$25 copay	
Non-preferred Brand	\$40 copay	
<b>Supply Limit</b>	30 days	

## MAIL ORDER (MAINTENANCE CHOICE)

If you take maintenance medications for conditions such as high blood pressure, diabetes, or asthma, you can save money by purchasing your prescriptions through CVS Caremark. **A 90-day generic prescription is available for a \$10 copay!**

### HMO Plan

<b>Mail Order</b>	
Generic	\$10 copay
Preferred Brand	\$50 copay
Non-preferred Brand	\$80 copay
<b>Supply Limit</b>	90 days

### PPO Plan

<b>Mail Order</b>	
Generic	\$10 copay
Preferred Brand	\$50 copay
Non-preferred Brand	\$80 copay
<b>Supply Limit</b>	90 days

**PPO & HMO Members:** When you use an out-of-network pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.

### AVOID PAYING 2X THE COST FOR 30 DAY SUPPLY

For prescriptions taken on a long-term basis, members will be allowed to obtain three fills of maintenance drugs at a retail pharmacy. For all subsequent fills of the same prescription, you must use CVS Caremark Mail Service Pharmacy or a local retail CVS Pharmacy. If you continue to fill your long-term prescription at a retail pharmacy, you will pay 2x the retail copayment and receive a 30-day supply. Please talk to your doctor about obtaining a 90-day prescription in these cases.

### IMPORTANT: BRAND NAME VS. GENERIC

If you request a brand-name drug when there is a generic equivalent, you must either purchase the generic drug, or pay 100% of the difference between the brand-name price and the generic price, plus the generic copayment. The only exception to this rule is if your doctor writes "Dispense As Written," or "DAW," on your prescription, in which case the brand-name drug will be dispensed at the brand name formulary or brand name non-formulary copay (depending on the drug).

# CVS Caremark Programs & Perks

## MINUTE CLINIC

MinuteClinic® walk-in medical clinics are staffed by nurse practitioners and physician assistants who specialize in family health care. They care for children and adults, every day with no appointment needed, at \$0 copay for you and your eligible dependents!

While life happens, they can help you feel better. MinuteClinic® practitioners can:

- ✓ Treat more than 125 minor illnesses & injuries
- ✓ Provide vaccines, physicals, screenings & more
- ✓ Write prescriptions, when medically appropriate
- ✓ Treat adults and children 18 months and older
- ✓ Share records with your primary care provider, with your permission

## CVS VACCINE PROGRAM

CVS Caremark Vaccine Services allows members to visit any CVS/pharmacy, including any CVS Minute Clinic, for approved vaccinations. Vaccinations are available whenever there is an immunizing pharmacist on duty.

**No appointment is necessary and there is no cost to you or your family.**

## CVS DISCOUNTS

ExtraCare Health Card holders receive a 20 percent discount on regular, non-sale priced, CVS/pharmacy Brand health-related items. Call (888) 543-5938 to combine your COLB ExtraCare Card with your personal CVS ExtraCare Card for additional savings.

## CASH PAY SERVICES

- ✓ Camp & Sports physicals
- ✓ DOT physical
- ✓ Eyelash lengthening consultation
- ✓ Pre-Travel consultation
- ✓ Malaria
- ✓ Motion sickness prevention
- ✓ TB test
- ✓ Strep throat test
- ✓ Traveler's diarrhea prevention & care
- ✓ Typhoid
- ✓ Urine Collection
- ✓ Vitamin B12 injections

## CVS/PHARMACY AT TARGET

Members can get their 30-day or 90-Day Maintenance Choice fills at any CVS or Target location.

## CONDITION ALERTS

City of Long Beach employees are automatically enrolled in the CVS Condition Alerts Program which is a comprehensive approach to addressing RX and medical gaps. The program's goals include:

- Continuous review of pharmacy claims, medical claims and lab data for a broader view of member's physician care plan
- Establish a comprehensive member profile including both Rx and medical gaps
- Identify potential gaps in care for over 100+ conditions
- Support members in all points of therapy, in accordance with their physician care plan

## DIABETES MANAGEMENT (ANTHEM PPO & HMO MEMBERS)

**Transform Diabetes Care** is designed to deliver better overall care and lower costs for eligible Anthem PPO and HMO members with diabetes. This comprehensive program targets medication adherence, blood glucose control and behavioral improvement to help improve member health outcomes. Program benefits include:

- **Telcare connected meter (optional)** gives members the opportunity to enroll in the Telcare connected meter. This connected meter allows you to track your levels, see trends, have your data analyzed by a Diabetic counselor.
- **Two diabetes monitoring visits per year** at any MinuteClinic® location at no out-of-pocket cost to you.
- **Personalized, one-on-one coaching with a CVS Pharmacy® pharmacist.** Just stop by CVS Pharmacy® or call the number on your member ID card to speak with a CVS Caremark® pharmacist.

**The Diabetic Bundling Program** waives the cost of diabetic supplies when you purchase them on the same day as your insulin. Under this program, diabetic supplies such as syringes and needles would be at a \$0 member cost share if purchased on the same day as the insulin and if the insulin claim is processed first.

# What is Medicare?

**Medicare** is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

## Medicare has:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicare Part C (Combines Part A and Part B Coverage)
- Medicare Part D (Prescription Drug Coverage)

**Medicare Part A** helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. You must meet certain conditions to get these benefits. **Cost:** You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. For 2019, you pay up to \$437 each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher. In most cases, if you choose to buy Part A, you must also purchase Part B and pay monthly premiums for both.

**Medicare Part B** helps cover doctors' services, hospital outpatient care, and home health care. Medicare Part B is optional. You have to enroll in Part B and pay a monthly premium. Your monthly premium depends on your income. Part B also covers some preventive services. **Cost:** Most people pay the standard premium amount (\$135.50 each month in 2019). However, if your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you could pay more. Premium amounts can change each year depending on your income. Current Medicare Part B premium amounts (based on 2017 tax returns and income levels) are listed below. If you have questions about your Medicare premiums, you can contact Social Security at 1-800-772-1213, Monday through Friday from 7 a.m. to 7 p.m., or TTY call 1-800-325-0778.

File Individual Tax Return	File Joint Tax Return	You Pay Each Month
\$85,000 or less	\$170,000 or less	<b>\$135.50</b>
Above \$85,000 up to \$107,000	Above \$170,000 up to \$214,000	<b>\$189.60</b>
Above \$107,000 up to \$133,500	Above \$214,000 up to \$267,000	<b>\$270.90</b>
Above \$133,500 up to \$160,000	Above \$267,000 up to \$320,000	<b>\$352.20</b>
Above \$160,000 up to \$500,000	Above \$320,000 up to \$750,000	<b>\$433.40</b>
Above \$500,000	Above \$750,000	<b>\$460.50</b>

**Medicare Advantage Plans (Part C)** are another way to get your Medicare benefits. They combine Part A, Part B, and, sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services. The City of Long Beach offers two Medicare Advantage Plans, UnitedHealthcare® Group Medicare Advantage (PPO) and Scan Health Plan.

**Medicare Part D** is a prescription drug option run by Medicare-approved private insurance companies to help cover the cost of prescription drugs. How it Works: Each year, the member is required to meet a Deductible (not more than \$415 in 2019) before their Prescription Drug Plan begins to pay its share of covered drugs. (Not all members are required to meet this deductible.) Once the deductible has been met, the member pays a copay or coinsurance amount (amounts vary among different Medicare Drug Plans), and the Medicare Drug plan pays its share of each covered drug until they together reach the combined Initial Coverage Limit (\$3,820 in 2019, plus the Deductible). After the Initial Coverage Limit is reached, the member is now in the **Coverage Gap**. In 2019, members are required to pay 25% of their Medicare Plan's covered cost of brand name drugs and 37% of the covered cost for generic drugs. Once the member has paid the out-of-pocket threshold (\$5,100 in 2019), the Coverage Gap ends and **Catastrophic Coverage** begins. Under the Catastrophic Coverage, the member pays only a small coinsurance or copayment for each covered drug until the end of the plan year.

You will receive enrollment information from Medicare in the weeks ahead. If you are covered by the Anthem Blue Cross Medicare Supplement Plan, **you do not have to enroll in Medicare Part D**; however, if your prescription needs exceed the \$2,000 maximum you have the option to enroll in Medicare Part D under the two (2) month Special Enrollment Period. You should notify the City's employee benefits division at (562) 570-6302 to let them know you now have a Medicare Part D plan. They will also explain any additional information you should know. Once you have enrolled in a Medicare Part D and wish to change plans, the enrollment period is October 15th through December 7th of each year. **Note: When you enroll in either the SCAN Health Plan or UnitedHealthcare® Group Medicare Advantage (PPO), you DO NOT need to enroll in Medicare Part D through Centers for Medicare & Medicaid Services (CMS), as SCAN or UnitedHealthcare® will automatically enroll you in Medicare Part D upon completion of the SCAN or UnitedHealthcare® Retiree application.**

Note: Details regarding our plans for Medicare eligible retirees can be found on the following pages. For the most current Medicare rates and information, please visit [Medicare.gov](https://www.Medicare.gov).

# Medical - Retirees 65+ and those eligible for Medicare (Must have Parts A & B)

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

City of Long Beach offers you a total of three choices; two Medicare Advantage Plans and one Medicare Supplement Plan. The two Advantage plans offered are the UnitedHealthcare® Group Medicare Advantage (PPO) plan and the SCAN Medicare Advantage plan. We also offer the Anthem Blue Cross Medicare Supplement plan. Medicare eligible retirees must have Medicare Parts A & B.

## SCAN HEALTH PLAN

SCAN Health Plan Medicare Advantage Plan offers a network of Primary Care Physicians, Specialists and Hospitals. You must use plan providers, except in emergency or urgent care situations or for out-of-area renal dialysis. If you have obtain routine care from an out-of-network providers neither Medicare nor SCAN Health Plan will be responsible for the costs. Eligible members must use network pharmacies to access their prescription benefit except under non-routine circumstances.

### SILVERSNEAKERS®

No cost gym membership with access to all basic amenities including pool, spa, specialized fitness classes, walking groups and social events. SCAN members are also enjoy access to healthy recipes and fitness advice. For participating fitness locations, just call (800) 522-5560 or visit [Silversneakers.com](http://Silversneakers.com).

## UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (PPO) PLAN

UnitedHealthcare® Group Medicare Advantage (PPO) plan is a Medicare Advantage plan that delivers all the benefits of Original Medicare (Part A & B), includes prescription drugs (Part D) and offers additional benefits and features.

With Medicare Advantage PPO plan, you are not required to select a Primary Care Provider (PCP) and there is no referral needed to see a specialist. The plan also offers you access to a large network of participating providers who accept Medicare assignments and will submit claims directly to UnitedHealthcare® for payment, not Medicare.

UnitedHealthcare® Group Medicare Advantage (PPO) plan strives to make it easier by giving you the tools and resources you may need to help make good health decisions for you. You have access to a secure website that provides information on valuable programs and resources, as well as provider and pharmacy information. Log onto [UHCRetiree.com](http://UHCRetiree.com) for more details.

### SILVERSNEAKERS®

Stay active with SilverSneakers® Fitness Program. Members receive basic fitness memberships to more than 13,000 participating locations. For members who don't have access to SilverSneakers® location, you have the option to enroll in SilverSneakers® Steps for personalized fitness programs that best fit your needs – general fitness, strength, walking or yoga.

Disclaimer: Consult a health care professional before beginning any exercise program. Availability of the SilverSneakers® program varies by plan/market. Refer to your Evidence of Coverage for more details. Healthways and SilverSneakers® are registered trademarks of Healthways, Inc. and/or its subsidiaries. © 2016 Healthways, Inc. All rights reserved.

## ANTHEM MEDICARE SUPPLEMENT

The Anthem Blue Cross Medicare Supplement PPO Plan is designed to supplement Medicare coverage. You have access to Anthem's network of PPO doctors and hospitals. As an Anthem member, you also have access to Anthem's wellness and health resources, including LiveHealth Online, ConditionCare, Mobile Consumer app, etc. (Refer to pages 11 & 12).

# Medical Summary – Medicare Advantage Plans

Plan Provisions	SCAN Health Plan Medicare Advantage Plan	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	
	In-Network	In-Network	Out-Of-Network
<b>Annual Out-of-Pocket Max (Individual/Family)</b>	\$3,400	Unlimited	Unlimited
<b>Office Visit</b>	\$5 copay per visit	No Charge	No Charge
<b>Outpatient X-ray &amp; Lab</b>	No Charge	No Charge	No Charge
<b>Home Health Care</b>	No Charge; may require prior authorization and referral from your doctor	No Charge	No Charge
<b>Preventive Services</b>	No Charge	No Charge	No Charge
<b>Chiropractic Care</b>	You can self-refer to a Plan Chiropractor in network for a \$5 copay/visit (up to 20 visits per year)	No Charge (Medicare-covered Chiropractic Visits only)	No Charge (Medicare-covered Chiropractic Visits only)
<b>Acupuncture</b>	Not Covered	Not Covered	Not Covered
<b>Inpatient Hospitalization</b>	No Charge	No Charge	No Charge
<b>Outpatient Surgery</b>	No Charge	No Charge	No Charge
<b>Emergency Room (copay waived if admitted)</b>	\$50 copay/visit \$25 copay for non-network out-of-area urgent care	No Charge	No Charge
<b>Durable Medical Equipment</b>	No Charge	No Charge	No Charge
<b>Physical Therapy</b>	\$5 copay per visit	No Charge	No Charge
<b>Skilled Nursing Facility</b>	No Charge for 100 days per benefit period	No Charge (up to 100 days)	No Charge (up to 100 days)
<b>Hospice Care</b>	No Charge from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.	No Charge	No Charge
<b>Inpatient Mental Health &amp; Substance Abuse</b>	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital
<b>Outpatient Mental Health &amp; Substance Abuse</b>	\$5 copay per visit	No Charge	No Charge

# Medical Summary – Medicare Advantage Plans

Plan Provisions	SCAN Health Plan Medicare Advantage Plan	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	
	In-Network	In-Network	Out-Of-Network
<b>Routine Dental Benefits</b>	<p>Provided by Delta Dental through the DeltaCare network. \$0 copay for exam 2 cleanings and x-rays every six months.</p> <p>To find a dentist, just call (800) 422-4234 or visit <a href="http://www.deltadentalins.com">www.deltadentalins.com</a></p>	Not Included. Dental benefits are limited to what is covered by Medicare	Not Included. Dental benefits are limited to what is covered by Medicare
<b>Routine Vision Benefits</b>	<p>Provided by EyeMed. \$3 copay for exam \$20 copay for lenses \$100 allowance for glasses and/or \$130 allowance for contacts every two years.</p> <p>To find an EyeMed Vision Care provider near you, just call (844) 226-2850</p>	No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)	No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)

## INDEPENDENT LIVING POWER (SCAN MEMBERS ONLY)

Independent Living Power® enables retirees that qualify to continue living at home. This service helps you during recovery from a hospital stay or provide support during an acute or long-term illness. The benefits provide extra help necessary to remain out of a nursing home. Services are available in Los Angeles, Orange, Riverside and San Bernardino counties. Qualifying members are eligible for up to \$500 per month for these services:

- ✓ Homemaker service
- ✓ Home delivered meals
- ✓ Personal care
- ✓ Emergency response team
- ✓ Unlimited routine transportation
- ✓ Personal care coordinator
- ✓ Inpatient custodial care
- ✓ In-home caregiver relief



# Prescription Drugs - Medicare Advantage Plans

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs.

## PHARMACY

SCAN Health Plan Medicare Advantage Plan	
<b>Pharmacy</b>	
Tier 1: Preferred Generic	\$7 copay
Tier 2: Generic	\$7 copay
Tier 3: Preferred Brand	\$14 copay
Tier 4: Non-Preferred Brand	\$14 copay
Tier 5: Specialty	\$40 copay
Tier 6: Select Care Drugs	\$14 copay
<b>Supply Limit</b>	30 days

### UnitedHealthcare® Group Medicare Advantage (PPO) Plan

<b>Pharmacy</b>	
Tier 1: Generic	\$10 copay
Tier 2: Preferred Brand	\$25 copay
Tier 3: Non-Preferred Drugs	\$40 copay
Tier 4: Specialty	\$40 copay
<b>Supply Limit</b>	30 days

Save on the cost of generic prescription drugs through Pharmacy Saver™. No additional enrollment is necessary. To see listing of drugs available through Pharmacy Saver or to find a participating pharmacy, visit [UnitedPharmacySaver.com](https://www.unitedpharmasaver.com).

Disclaimer: Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

## MAIL ORDER

If you take maintenance medications for conditions such as high blood pressure, diabetes, or asthma, you can save money by purchasing your prescriptions through mail order. For two copays, you receive a 90-day supply rather than a 30-day supply.

SCAN Health Plan Medicare Advantage Plan	
<b>Pharmacy</b>	
Tier 1: Preferred Generic	\$14 copay
Tier 2: Generic	\$14 copay
Tier 3: Preferred Brand	\$28 copay
Tier 4: Non-Preferred Brand	\$28 copay
Tier 5: Specialty	Not Offered
Tier 6: Select Care Drugs	\$28 copay
<b>Supply Limit</b>	90 days

90 day supply can also be dispensed at retail pharmacy through a SCAN preferred pharmacy network. This network offers SCAN members lower copayments for many drugs.

### UnitedHealthcare® Group Medicare Advantage (PPO) Plan

<b>Mail Order</b>	
Tier 1: Generic	\$20 copay
Tier 2: Preferred Brand	\$50 copay
Tier 3: Non-Preferred Drugs	\$80 copay
Tier 4: Specialty	\$80 copay
<b>Supply Limit</b>	90 days

Please note that additionally, members who reach the Catastrophic phase pay the following for their prescription drugs:

- \$3.60 copay for generics
- \$8.95 copay for all other drugs

Once you've spent \$6,350 out-of-pocket in 2020, you're out of the coverage gap. Once you get out of the coverage gap (Medicare prescription drug coverage), you automatically get "catastrophic coverage." It assures you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year. Go to [Medicare.gov](https://www.medicare.gov) for more information.

# Medical Summary – Medicare Supplement Plan

## Plan Provisions

## Anthem Blue Cross Medicare Supplement

	In-Network	Out-Of-Network
<b>Annual Out-of-Pocket Max (Individual/Family)</b>	Unlimited	Unlimited
<b>Office Visit</b>	No Charge; plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Outpatient X-ray &amp; Lab</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Home Health Care</b>	20% after a \$50 calendar year deductible up to a lifetime maximum of \$5,000 (100 visits per calendar year)	
<b>Preventive Services</b>	Medicare will cover one-time preventive physical exam within the first 6 months that you have Medicare Part B. Routine physicals are not covered.	
<b>Chiropractic Care</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Inpatient Hospitalization</b>	No Charge; Days 1-60: Medicare deductible paid at 100% Days 61-90: All Covered Expenses not payable by Medicare will be paid at 100% Days 91-100: All Covered Expenses not payable by Medicare will be paid at 100% Days 101+: Not Covered	No Charge; Days 1-60: Medicare deductible paid at 100% Days 61-90: Medicare deductible paid at 100% Days 91-100: Plan pays the usual charges for semi-private room services for the hospital concerned Days 101+: Not Covered
<b>Outpatient Surgery</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Emergency Room (copay waived if admitted)</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Durable Medical Equipment</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit

# Medical Summary – Medicare Supplement Plan

## Anthem Blue Cross Medicare Supplement

Plan Provisions	In-Network	Out-Of-Network
<b>Physical Therapy</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Skilled Nursing Facility</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare up to the plan limit of 100 days	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100 <sup>th</sup> day.
<b>Hospice Care</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Inpatient Mental Health &amp; Substance Abuse</b>	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
<b>Outpatient Mental Health &amp; Substance Abuse</b>	No Charge; Plan pays 100% of the eligible charges for the service subject to a \$250 calendar year maximum	Plan pays the Medicare deductible and any applicable coinsurance for a confinement at a Medicare-participating hospital

# Prescription Drugs – Medicare Supplement Plan

Prescription drugs are covered under CVS Caremark and are subject to a paid maximum benefit of \$2,000 per calendar year (based on the retail cost and member copay of each prescription). For example, if your member copay is \$10 and the drug retails for \$40, then \$50 will be deducted from your annual maximum of \$2,000. Mail order is also available through CVS Caremark.

If you purchase prescription drugs out-of-network and need reimbursement, you must submit a completed claim form and receipt(s) to CVS Caremark. If you are not enrolled in a Medicare Part D plan, you must submit your claim for reimbursement within one year of the date that the prescription was filled.

**Please note:** Medicare Part D is an option for members whose prescription needs exceed the \$2,000 annual maximum. If you are enrolled in Medicare Part D, your benefits will be coordinated under the medical plan (based on retail cost of the drug), and you must submit claims for prescription drugs within three years of the date that the prescription was filled. Claim forms are available on [www.longbeach.gov/hr](http://www.longbeach.gov/hr).

You can also print the flip book version of the claim form from <https://alliantbenefits.cld.bz/CVSRxClaimForm>

## PHARMACY

Pharmacy	In-Network	Out-of-Network
Generic		\$10 copay
Preferred Brand		\$25 copay
Non-preferred Brand		\$40 copay or 30%
<b>Supply Limit</b>		30 days

## MAIL ORDER

Mail Order	In-Network	Out-of-Network
Generic		\$10 copay
Preferred Brand		\$50 copay
Non-preferred Brand		\$80 copay or 30%
<b>Supply Limit</b>		90 days

# Dental

City of Long Beach gives you a choice between two dental plans through Delta Dental Plan of California. The choice is yours. When it comes to dental health, you want benefits that provide you with the best balance of value and coverage. Delta Dental PPO<sup>SM</sup> and DeltaCare<sup>®</sup> USA both offer comprehensive dental coverage, quality care and excellent customer service. Each plan has its own advantages.

**NOTE: If you elect to waive dental benefits for 2020, upon re-enrollment, there will be a late entrant penalty of a 12-month waiting period for all major services including orthodontia (applies only to the DPPO plan).**

## DELTA DENTAL DPPO PLAN

**NEW IN 2020** Effective January 1, 2020, there will be some enhancements made to our Delta Dental DPPO Plan:

- Dental implant coverage at 50% coinsurance.
- Future moms can get a third screening at no additional cost
- Diagnostic and Preventative (D&P) Maximum Waiver Program

The Delta Dental DPPO plan allows you to use any dentist of your choice. Your out-of-pocket costs are determined by the dentist you use - a Delta PPO dentist, Delta Premier Dentist, or an out-of-network dentist. It is to your advantage to select a dentist who participates in the Delta PPO or Premier network. For care from Delta PPO directory providers, you pay no deductible and the plan pays a plan year maximum of \$2,000.

When you use a Delta "Premier" dentist or an out-of-network dentist, you first pay a deductible, then the plan pays a percentage of your costs up to \$1,000 each plan year in covered benefits. However, by using one of the many Delta dentists throughout California, you will receive the advantage of a lower fee than you would receive from an out-of-network dentist.

Note: The \$2,000 (DPPO dentist) and \$1,000 (Premier and out-of-network dentist) plan maximums are not cumulative. The maximum benefit you receive under your dental plan cannot exceed \$2,000 per year.

With the Delta Dental DPPO Plan, you have the option to go to a specialist of your choice without pre-approval, and you may change your dentist at any time without pre-approval. Claim forms are required only if you receive care from out-of-network dentists. Please note that dental cleanings are based on a calendar year.

## DIAGNOSTIC & PREVENTIVE (D&P) WAIVER PROGRAM

Protect your teeth and your wallet with the new Diagnostic and Preventive Waiver Program. This program promotes good oral health and may reduce the need for more expensive, restorative dental services that can result from undetected oral or related health problems. Under the program, the annual maximum is waived for you and your dependents when diagnostic or preventive services are obtained through a Delta Dental DPPO provider. Please see the chart below to for an example of how the Waiver Program works:

Without D&P Maximum Waiver			
Dental Treatment	Delta Dental Pays	Enrollee Pays	Maximum Remaining
D&P*	\$350	\$0	\$1,650

With D&P Maximum Waiver			
Dental Treatment	Delta Dental Pays	Enrollee Pays	Maximum Remaining
D&P*	\$350	\$0	\$2,000

\* Includes exams, x-rays, cleanings covered at 100% for 2 visits

## DELTACARE USA DHMO PLAN

DeltaCare USA DHMO Plan - When you enroll, you choose a dentist who belongs to the DeltaCare USA DHMO network of providers. DeltaCare USA DHMO dentists are located in most areas of California. When you use the dentist you select at the time you enroll, treatments are covered at the stated copay. However, if you use any other dentist, you receive no benefits. Each dependent may choose a different dentist and claim forms are not required. The copay schedule is available on [Deltadentalins.com](https://www.deltadentalins.com).

### NO ID CARD NECESSARY

Just provide your dental office with your name, birth date and enrollee ID or social security number. Register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.



## Dental Summary

Plan Provisions	DeltaCare USA DHMO	Delta Dental of California DPPO	
	In-Network	In-Network	Out-Of-Network
<b>Calendar Year Deductible (Individual/Family)</b>	\$0 \$0	\$0 \$0	\$50 \$150
<b>Annual Plan Maximum</b>	Not Applicable	\$2,000 <sup>1</sup> per person	\$1,000 <sup>1</sup> per person
<b>Waiting Period</b>	Not Applicable	12 Months for Major Services, Prosthodontics, and Orthodontics (only applicable to late entrant)	12 Months for Major Services, Prosthodontics, and Orthodontics (only applicable to late entrant)
<b>Diagnostic and Preventive (Oral exams, teeth cleanings, x-rays)</b>	\$0-\$45 copay (varies by service; refer to fee schedule)	Plan pays 100% <sup>2</sup> (cleanings based on calendar year)	Plan pays 100% <sup>3</sup> (cleanings based on calendar year)
<b>Basic Services</b>			
Restorative	\$0-\$195 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% <sup>2</sup>	Plan pays 80% after deductible <sup>3</sup>
Endodontics	\$0-\$220 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% <sup>2</sup>	Plan pays 80% after deductible <sup>3</sup>
Periodontics	\$0-\$195 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% <sup>2</sup>	Plan pays 80% after deductible <sup>3</sup>
<b>Major Services (includes prosthodontics)</b>	\$0-\$195 copay (varies by service; see contract for fee schedule) then 100%	Plan pays 80% <sup>2</sup>	Plan pays 80% after deductible <sup>3</sup>
<b>Dental Implants</b>	Not Covered	Plan pays 50% <sup>2</sup>	Plan pays 50% after deductible <sup>3</sup>
<b>Orthodontic Services</b>			
Orthodontia	\$200-\$1,900 copay (refer to fee schedule)	Plan pays 50% <sup>2</sup>	Plan pays 50% <sup>3</sup>
<b>Lifetime Maximum</b>	Covers up to 24 months of active treatment	Adult: \$1,000 Child: \$2,000	Adult: \$1,000 Child: \$2,000 (combined with in-network)
<b>Dental Accident</b>	N/A	Plan pays 100% <sup>2,4</sup>	Plan pays 100% <sup>3,4</sup>

1. Plan year maximums are not cumulative.
2. Based on DPPO allowed fees.
3. Based on Delta's allowed fees.
4. No separate maximum per person per calendar year.

# Vision

City of Long Beach provides vision coverage through Vision Service Plan (VSP). VSP is committed to improving wellness through eye care, and has been voted consumers' #1 choice in vision care for five years in a row. VSP Choice network features a broad provider network with substantial access across the United States in a variety of settings.

## NEW IN 2020

Medicare-eligible retirees and their dependents can now enroll in The City's VSP Voluntary Vision Benefits in the 2020 plan year!

## THE NETWORK

You can choose from over 77,000 access points, including the largest national network of independent doctors and nearly 4,900 participating retail chain locations, including Costco. For added convenience, 91% of VSP Doctors offer early morning, evening and weekend appointments, and 24-hour access to emergency care. If you prefer to use a non-network provider, this option is still available under our plan; however, the benefit allowances are lower.

### USING YOUR VSP BENEFIT IS EASY

- Find a VSP doctor who's right for you at [VSP.com](https://www.vsp.com).
- Review your plan coverage before your appointment.
- At your appointment, tell them you have VSP. **There's no ID card necessary but you can print one on [VSP.com](https://www.vsp.com).**

## THE PERKS

In addition to getting true freedom of choice in providers, VSP also offers:

- ✓ WellVision Exam® – the most thorough eye exam, exclusive to VSP
- ✓ Exclusive Member Extras, like rebates, special offers, and promotions
- ✓ Extra \$20 to spend on featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West and more.
- ✓ Eyecare from the best doctors – VSP doctors have met the highest credential requirements
- ✓ The perfect pair of glasses from a wide selection of frames to meet your style and budget
- ✓ Shop for eyewear online at VSP's [Eyeconic.com](https://www.eyeconic.com)
- ✓ Receive the full frame allowance even when you get your prescription filled at Costco, Sam's Club, or Walmart.

## WHAT YOUR EYES SAY ABOUT YOU

### Your eyes may reflect serious health conditions

Viewing blood vessels in the eyes allows vision care providers to see what's going on throughout your body. This often helps them detect signs of health problems, such as hypertension and diabetes.



# Vision Summary

Comprehensive eye exams are covered in full, every 12 months. Please note that the contact lens exam is not part of the comprehensive eye exam. A separate copay applies for those that elect the contact lens exam. You must wait a complete 12 months between exams. One pair of eyeglass lenses, frames, and/or contact lenses is also covered every 12 months. To receive 100% coverage, you must use a VSP provider. **To locate a VSP provider, go to [Vsp.com](https://vsp.com) or contact (800) 877-7195. VSP Member Services representatives are available Monday through Friday from 5:00 am to 8:00 pm, Saturday from 7:00 am to 8:00 pm and Sunday from 7:00 am to 7:00 pm PST.**

## Vision Service Plan (VSP)

	In-Network	Out-Of-Network
<b>WellVision Exam</b>		
Benefit	Plan pays 100%	Up to \$68
Frequency	12 months	12 months
<b>Prescription Glasses</b>		
Frames	Up to \$90 (or \$110 for featured brands)	Up to \$50
Single Vision Lens	Plan pays 100%	Up to \$45
Lined Bifocal Lens	Plan pays 100%	Up to \$63
Trifocal Lens	Plan pays 100%	Up to \$80
Frequency	12 months	12 months
<b>Contacts (in lieu of glasses)</b>		
Contact Lens Materials	Up to \$100, copay does not apply	Up to \$100
Contact Lens Exam (fitting & evaluation)	Up to \$60	
Frequency	12 months	12 months

## EXTRA SAVINGS

### Glasses and Sunglasses

- ✓ Extra \$20 to spend on featured frame brands - visit [Vsp.com/specialoffers](https://vsp.com/specialoffers) for details
- ✓ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam

### Retinal Screening

- ✓ Max \$39 copay on routine retinal screening

### Laser Vision Correction

- ✓ Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities



# Long Term Care

The City of Long Beach is pleased to offer Long Term Care Insurance. This plan provides financial help if you require care in a nursing facility, in assisted living or at home, as a result of a loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age. Qualifying for benefits is based upon a need for assistance with any two of seven activities of daily living including eating, bathing, dressing, toileting, continence, ambulating, or transferring, and/or cognitive impairment such as dementia or Alzheimer's disease.

The basic plan (Plan 1) provides \$1,000 of monthly benefits for up to three years in a nursing facility. Newly benefit eligible employees who apply during their initial enrollment period are eligible for guaranteed issue coverage up to \$4,000 of monthly benefits. Additional amounts of coverage are medically underwritten. After the initial enrollment period – application for coverage or additional coverage requires health questions and medical underwritten.

Plan “Buy up Options” allow you to increase monthly benefits in units of \$1,000 up to \$8,000 monthly, and to add professional home care and inflation protection, based on the following plan provisions:

## PLAN 1

- ✓ 3-Year Facility Benefit Duration
- ✓ 60-day Elimination Period
- ✓ Return of Premium-Reduction
- ✓ Long-Term Care Facility

## PLAN 2

Includes all the provisions of Plan 1, in addition to Professional Home Care

## PLAN 3

Includes all the provisions of Plan 1, in addition to 5% Compound Inflation

## PLAN 4

Includes all the provisions of Plan 1, in addition to Professional Home Care and 5% Compound Inflation

The plan is portable and can be taken with you if your employment discontinues or upon retirement. The plan is also available (underwriting required) to spouses, parents, grandparents, and in-laws, even if you don't apply for LTC coverage for yourself.

**The younger you are, the lower the premium. Premiums are based on age at time of enrollment and the level of benefits selected – the premiums do not increase as you age as long as you remain enrolled in the plan and at the same benefit level chosen at the time of enrollment.**

## CALCULATE YOUR LTC PREMIUM

$$\begin{array}{l} \text{Rate for chosen} \\ \text{plan} \end{array} \times \begin{array}{l} \text{Monthly Benefit} \\ \text{Amount}/\$1,000 \end{array} = \begin{array}{l} \text{Your} \\ \text{Monthly} \\ \text{Premium} \end{array}$$

For more information, please visit the Unum website:  
<http://unuminfo.com/cityoflongbeach/index.aspx>

	Plan 1	Plan 2	Plan 3	Plan 4
Age	Option	Option	Option	Option
18-30	\$1.80	\$3.00	\$6.60	\$9.40
35	\$2.10	\$3.40	\$7.60	\$10.70
40	\$2.60	\$4.10	\$8.90	\$12.30
45	\$3.40	\$5.20	\$10.60	\$14.60
50	\$4.50	\$6.60	\$12.70	\$16.70
55	\$6.40	\$8.70	\$15.90	\$19.80
60	\$9.60	\$11.90	\$20.50	\$24.10
65	\$16.30	\$18.70	\$30.70	\$34.10
70	\$27.90	\$30.80	\$46.10	\$50.00

See the glossary of terms section for brief explanations of LTC plan provisions.



## City of Long Beach 457 Deferred Compensation Plan

# Your City of Long Beach 457 Account

### WHY KEEP YOUR MONEY IN YOUR CITY OF LONG BEACH 457 ACCOUNT

You can keep your City of Long Beach 457 account and enjoy the same benefits for your lifetime! Here are a few steps to help you understand the options available to you after you separate from service with the City.

#### STEP 1: Prepare for your new journey

Meet with your dedicated representative before you separate from service (or soon after) to review your investments, savings, and future options.

#### STEP 2: Compare your options.

Here are a few things you'll benefit from by keeping your City of Long Beach 457 account:

- ✓ Personal assistance from your local representative
- ✓ Financial-planning assistance from a CERTIFIED FINANCIAL PLANNER™ professional (CFP)



#### STEP 3: Decide what's best for you.

Your plan representative can help you with the following long-term goals:

- ✓ Roll over tax-deferred money into your Long Beach 457 account for easier management. If you decide to move outside money into your City of Long Beach 457 account, you'll get the same great value, investment options, services and competitive pricing!
- ✓ Starting a new job? Review your options and determine if keeping both accounts will offer you additional diversification and services.
- ✓ Broader investment menu. Your plan's brokerage option provides you with additional investment choices. If you decide to move money out of your City of Long Beach 457 account, consider leaving a balance if you want to continue enjoying plan benefits.



**NEED HELP? Contact your local team or visit the plan's website: [www.457longbeach.org](http://www.457longbeach.org)**



**Tisha Neal**  
Retirement Plan Specialist  
(866) 731-1061  
[tneal@icmarc.org](mailto:tneal@icmarc.org)



**Scott M. Eason**  
CERTIFIED FINANCIAL  
PLANNER™  
(866) 754-7334  
[Season@icmarc.org](mailto:Season@icmarc.org)



## Memorial Care Hospital Ambassadors

In 2020, the City of Long Beach Nurse Ambassador Program will be phased out by Memorial Care Hospital. However, Memorial Care Hospital will continue to be an Anthem in-network hospital and valued partner of the City. Assistance for hospitalized patients at Memorial Care Hospital is available by calling either of the following:

- **Nurse Facilitator:** 1-866-276-3627 Prompt 2
- **Hospital Liaison:** 1-800-MEMORIAL

The City is preparing to announce a new type of benefit resource to assist enrolled employees, their dependents, parents and parents-in-laws with comprehensive health care navigation, regardless of the Anthem health plan you are enrolled in, or the hospital facility you utilize. More details to come!

## Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA was introduced to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of health care for individuals and the government. It introduced mechanisms such as mandates, subsidies, employer and employee reporting requirements, and insurance exchanges. The regulations under the ACA continue to evolve, and we want to make sure you're in the loop and aware of how you and the City are affected by these regulations.

Currently, both health insurance providers and employers with 50 or more full-time employees have reporting requirements to ensure they are meeting health care coverage obligations. The information-reporting obligations are meant to provide the IRS with policy details for each person covered under our health plans.

The City is required to report information such as:

- Your length of full-time status
- Proof of the minimal essential coverage offered
- Your coverage dates and how much you pay for coverage
- Taxpayer identification numbers for you and your dependents
- The addresses we have on file for you and your enrolled dependents

In addition to reporting this information to the IRS, we must also share this information with you in order to help you meet your tax filing requirements. You will receive a form 1095-C along with your W-2 form for the 2019 tax year no later than January 31, 2020. Please retain this document for your records, and provide it to your tax consultant when you complete your tax filing for the 2018 tax year.

# Key Terms

## MEDICAL/GENERAL TERMS

<b>Allowable Charge</b>	The negotiated amount that in-network providers have agreed to accept as full payment.
<b>Balance Billing</b>	A practice where out-of-network providers bill a member for charges that exceed the plan's allowable charge.
<b>Coinsurance</b>	The percentage cost share between the insurance carrier and a member.
<b>Copay</b>	The dollar amount a member must pay directly to a provider at the time of service.
<b>Explanation of Benefits (EOB)</b>	The statement you receive from the insurance carrier that details how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay your provider until you have received this except for copays. Applies to PPO only.
<b>Family Deductible</b>	The maximum dollar amount any one family will pay out in individual deductibles in a year.
<b>Individual Deductible</b>	The dollar amount a member must pay each year before the plan will pay benefits for certain services.
<b>In-Network</b>	Services received from providers (doctors, hospitals, etc.) who have agreed to limit their fees for health plan members to a negotiated allowable charge.
<b>Out-of-Network</b>	Services received from providers (doctors, hospitals, etc.) who have not agreed to limit their fees to a negotiated allowable charge. Out-of-network benefits are usually lower and additional balance billing charges will apply whenever the provider charges more than the plan's allowable charge.
<b>Out-of-Pocket Maximum</b>	That maximum amount that you will pay each year for covered services.
<b>Preventive Care</b>	A routine exam - usually yearly that may include a physical exam, immunizations and tests for cancer.

## PRESCRIPTION DRUG TERMS

<b>Brand Prescription Drug</b>	A drug which is produced and distributed under patent protection with a trademarked name from a single drug manufacturer. A generic drug may be available if the patent has expired.
<b>Dispense as Written (DAW)</b>	A prescription that does not allow for substitution of an equivalent generic or similar brand drug.
<b>Generic Prescription Drug</b>	A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.
<b>Maintenance Medications</b>	Medications taken on a regular basis for an ongoing condition. Examples of maintenance medications include oral contraceptives, blood pressure medication and asthma medications.

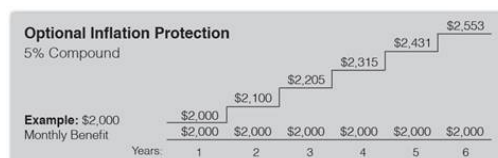
<b>Non-Preferred Brand Drug</b>	A brand drug for which alternatives are available from either the insurance carrier's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.
<b>Preferred Brand Drug</b>	A brand drug that an insurance carrier has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of their clinical effectiveness and their cost.
<b>Specialty Pharmacy</b>	Provide special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/AIDS.
<b>Step Therapy</b>	The practice of beginning drug therapy for a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

## DENTAL TERMS

<b>Basic Services</b>	Basic services generally include coverage for fillings and oral surgery.
<b>Diagnostic and Preventive Services</b>	Diagnostic and preventive services generally include services such as routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit the frequency of preventive exams and cleanings to two times a year.
<b>Endodontics</b>	Commonly known as root canal therapy.
<b>Implants</b>	Dental implants are surgically implanted replacements for the natural tooth root of missing teeth. Many dental plans do not cover implants.
<b>Major Services</b>	Generally include coverage for restorative dental work such as crowns, bridges, dentures, inlays and onlays.
<b>Orthodontia</b>	A benefit that is offered under some dental plans. It generally includes services for the treatment of alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.
<b>Periodontics</b>	The diagnosis and treatment of gum disease.
<b>Pre-Treatment Estimate</b>	An estimate that the insurance company provides detailing how much they will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

## LONG TERM CARE TERMS

<b>Return of Premiums</b>	A percentage of premiums paid toward LTC will be returned to your estate if you die before using LTC benefits. You must be under age 75 on the date of death and there must be proof that premiums were paid until date of death.
<b>5% Compound Inflation</b>	Adds 5% interest to the amount of participants' monthly benefits each January 1 of the calendar year. Compound inflation doubles in the 15th year of enrollment and there is no cap.



<b>60-day Elimination Period</b>	The 60 (consecutive) days elimination period is the amount of time a participant must wait before benefits become payable. This time period must be satisfied only once during the life of the plan
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# Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy #
Medical Plans				
Medical	Anthem Blue Cross HMO	(844) 653-7399	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross PPO	(844) 653-7399	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross Nurse Line	(800) 337-4770	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross Medicare Supplement	(877) 800-7339	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	(877) 714-0178	<a href="http://Uhcretiree.com">Uhcretiree.com</a>	15647
Medical	SCAN Health Plan	(877) 305-7226	<a href="http://Scanhealthplan.com/COLB">Scanhealthplan.com/COLB</a>	119
Pharmacy Benefit Manager				
Pharmacy	CVS Caremark	(855) 559-7917	<a href="http://Caremark.com">Caremark.com</a>	N/A
Dental Plans				
Dental	Delta Dental HMO	(800) 422-4234	<a href="http://Deltadentalins.com/colb">Deltadentalins.com/colb</a>	78506
Dental	Delta Dental PPO	(800) 765-6003	<a href="http://Deltadentalins.com/colb">Deltadentalins.com/colb</a>	3712
Vision Plan				
Vision	VSP	(800) 877-7195	<a href="http://VSP.com">VSP.com</a>	30069959
Behavioral Health and Emotional Well Being				
Mental Health	Anthem Blue Cross Behavioral Health Network	(800) 274-7767	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
City of Long Beach Employee Benefits				
COLB Employee Benefits	City of Long Beach	(562) 570-6303	<a href="mailto:Employee-Benefits@LongBeach.gov">Employee-Benefits@LongBeach.gov</a>	
IMPORTANT! Visit our internet website at <a href="http://www.longbeach.gov/hr/">http://www.longbeach.gov/hr/</a> for links to plan documents including Summary Plan Descriptions (SPDs), Summary of Benefits and Coverage (SBCs), Benefit Summaries, and much more!				

# Required Federal Notices

## AVAILABILITY OF PRIVACY PRACTICE NOTICE

We maintain the HIPAA Notice of Privacy Practices for City of Long Beach describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

## HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in City of Long Beach's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in City of Long Beach's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-60 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in City of Long Beach's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

## THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

# Required Federal Notices

## AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by City of Long Beach represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

City of Long Beach offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by City of Long Beach are available by visiting our internet website at <http://www.longbeach.gov/hr/> or Anthem's website at [Anthem.com/ca/colb](http://Anthem.com/ca/colb). You may also request a copy from Human Resources.

## NOTICE OF CHOICE OF PROVIDERS

The Anthem Blue Cross HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Anthem Blue Cross will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carriers directly.

You do not need prior authorization from Anthem Blue Cross or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at (844) 653-7399.

## MEDICARE PART D

### **Important Creditable Coverage Notice from City of Long Beach About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Long Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Long Beach has determined that the prescription drug coverage offered by City of Long Beach's health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

# Required Federal Notices

## MEDICARE PART D, CONTINUED

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan and drop your current City of Long Beach prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Since the existing prescription drug coverage under City of Long Beach is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Long Beach prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with City of Long Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the office listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Long Beach changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### **For more information about Medicare prescription drug coverage:**

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call (800) MEDICARE or (800) 633-4227. TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](https://www.socialsecurity.gov), or call them at (800) 772-1213. TTY users should call (800) 325-0778.

**Date:** January 1, 2020  
**Name of Entity:** City of Long Beach  
**Contact:** Human Resources  
**Address:** 411 West Ocean Blvd., 10th Floor, Long Beach, CA 90802  
**Phone:** (562) 570-6303

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

# Required Federal Notices

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447
ALASKA – Medicaid	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>
ARKANSAS – Medicaid	Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-692-7447)
COLORADO – Medicaid and CHIP	Health First Colorado (Colorado's Medicaid Program & Child Health Plan Plus (CHP+) Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711
FLORIDA – Medicaid	Website: <a href="http://flmedicaidtprecovery.com/hipp/">http://flmedicaidtprecovery.com/hipp/</a> Phone: 1-877-357-3268
GEORGIA – Medicaid	Website: <a href="http://www.medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">http://www.medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864
IOWA – Medicaid	Website: <a href="http://dhs.iowa.gov/hawki">http://dhs.iowa.gov/hawki</a> Phone: 1-800-257-8563

KANSAS – Medicaid	Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-785-296-3512
KENTUCKY – Medicaid	Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a> Phone: 1-800-635-2570
LOUISIANA – Medicaid	Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a> Phone: 1-888-695-2447
MAINE – Medicaid	Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a> Phone: 1-800-862-4840
MINNESOTA – Medicaid	Website: <a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739
MISSOURI – Medicaid	Website: <a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">https://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
MONTANA – Medicaid	Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
NEBRASKA – Medicaid	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA – Medicaid	Medicaid Website: <a href="https://dhcfp.nv.gov">https://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> Phone: 1-800-701-0710
NEW YORK – Medicaid	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a> Phone: 919-855-4100
NORTH DAKOTA – Medicaid	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742
OREGON – Medicaid and CHIP	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	Website: <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a> Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 855-697-4347, or (401) 462-0311 (Direct Rlite Share Line)
SOUTH CAROLINA – Medicaid	Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
TEXAS – Medicaid	Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
VERMONT– Medicaid	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a> Phone: 1-800-362-3002
WYOMING – Medicaid	Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a> Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

#### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

# Required Federal Notices

## NOTICE ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

City of Long Beach complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. City of Long Beach does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

City of Long Beach:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Language Line**.

If you believe that City of Long Beach has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**Contact: Language Line**

**Phone: (866) 874-3972**

**Email: [languageaccess@longbeach.gov](mailto:languageaccess@longbeach.gov) (document translation and interpretation available for Spanish, Khmer and Tagalog)**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Language Line** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).

# Required Federal Notices

## TAGLINES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

### Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 874-3972.

### Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 874-3972.

### Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 874-3972.

### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 874-3972 번으로 전화해 주십시오.

### Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (866) 874-3972.

### French Creole (Haitian Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 874-3972.

### Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (866) 874-3972.

### Arabic

(866) 874-3972: ١-xxx-xxx-xxxx مقرب لصوت. انما اب لكل رفاوتت ةي وغلل ادعاسملا تامدخ ناف، ةغلل ركذا ثدحتت تنك اذا: فطو ح لم

### Persian (Farsi)

دیری گب سامت (866) 874-3972 اب. دشاب یم مهارف امش یارب ناگیار تروصب ینابز تالیست، دینک یم وگتفگ یراف نابز مپ رگا: هجوت

### Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(866) 874-3972 まで、お電話にてご連絡ください。

### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական օգնություններ: Ձանգահարեք (866) 874-3972.

### French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (866) 874-3972.

### Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (866) 874-3972 'ਤੇ ਕਾਲ ਕਰੋ।

### Mon-Khmer, Cambodian

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ (866) 874-3972.

### German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (866) 874-3972.

Rev. 9/6/2019

Plan Type	Provider	Phone Number	Website	Policy #
<b>Medical Plans</b>				
Medical	Anthem Blue Cross HMO	(844) 653-7399	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross PPO	(844) 653-7399	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross Nurse Line	(800) 337-4770	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	Anthem Blue Cross Medicare Supplement	(877) 800-7339	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
Medical	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	(877) 714-0178	<a href="http://Uhcretiree.com">Uhcretiree.com</a>	15647
Medical	SCAN Health Plan	(877) 305-7226	<a href="http://Scanhealthplan.com/COLB">Scanhealthplan.com/COLB</a>	119
<b>Pharmacy Benefit Manager</b>				
Pharmacy	CVS Caremark	(855) 559-7917	<a href="http://Caremark.com">Caremark.com</a>	N/A
<b>Dental Plans</b>				
Dental	Delta Dental HMO	(800) 422-4234	<a href="http://Deltadentalins.com/colb">Deltadentalins.com/colb</a>	78506
Dental	Delta Dental PPO	(800) 765-6003	<a href="http://Deltadentalins.com/colb">Deltadentalins.com/colb</a>	3712
<b>Vision Plan</b>				
Vision	VSP	(800) 877-7195	<a href="http://VSP.com">VSP.com</a>	30069959
<b>Behavioral Health and Emotional Well Being</b>				
Mental Health	Anthem Blue Cross Behavioral Health Network	(800) 274-7767	<a href="http://Anthem.com/ca/colb">Anthem.com/ca/colb</a>	276800
<b>City of Long Beach Employee Benefits</b>				
COLB Employee Benefits	City of Long Beach	(562) 570-6303	<a href="mailto:Employee-Benefits@LongBeach.gov">Employee-Benefits@LongBeach.gov</a>	
<p>IMPORTANT! Visit our internet website at <a href="http://www.longbeach.gov/hr/">http://www.longbeach.gov/hr/</a> for links to plan documents including Summary Plan Descriptions (SPDs), Summary of Benefits and Coverage (SBCs), Benefit Summaries, and much more!</p>				